COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH

CLINIC RECEIPTS TRANSMITTAL

DEPOSIT DATE _____

CONTROL UNIT NUMBER _____

CLINIC NAME _____STATE PROVIDER NUMBER _____

Enclosed are Departmental Receipts numbered _____through _____ and:

Checks/money orders totaling	$ _____
Cash totaling	$ _____
for a grand total of	$ _____

REVENUE BY CATEGORY:	Short-Doyle	Federal Medi-Cal
Client Payments	$ _____	
Medicare Payments	$ _____	
Medi/Cal w/ Share of Cost		$ _____
Insurance Payments	$ _____	$ _____
Other	$ _____	
Grand Total Collections:	$ _____	$ _____

Revenue was collected _____through _____ (dates).

PREPARED BY:	**VERIFIED BY:**
Signature _____	_____
Title _____	_____
Telephone Number_____	_____